Office of Child Abuse Prevention
www.childsworld.ca.gov/PG2289.htm

The Federal Office of Management & Budget requires that all programs and practices supported by CBCAP funds be rated for their effectiveness. Please follow the steps below to rate your funded programs/practice.

Instructions:

1.Categorize each of your funded programs/practices under one of the levels on the following page. Expectation: the corresponding evidence of your program/practices level is available for review in the event of an audit. It is recommended that counties and funded partners keep a completed checklist for each CBCAP-funded program/practice for audit purposes.

2. Review the two definitions below to determine if the program/practice can be considered Evidence-Based or Emerging and Evidence-Informed:
a. ***Program:*** consists of a collection of practices that are done within specific known parameters (philosophy, values, service delivery, structure, and treatment components). This refers to a specific set of activities that forms the entire program.
b. ***Practice:*** consist of a skill, technique, and strategy that can be used by a practitioner. General strategies such as a "therapy" or "parenting classes" would not qualify as an EBP/EIP alone. The practice would need to be implementing a specific technique or components of a curriculum with positive evidence such as Parent-Child Interaction Therapy (PCIT).

3. Begin with Level 1 and assess a "yes" or "no" for each program feature. If all answers in a Level are "yes", go on to the next Level.

4. Program/practices must receive a "yes" response for every item in a Level in order to meet the criteria for that Level.

5. Future intentions or partially-completed work should be recorded as a "No".

6. Continue through the self-assessment until you have determined the appropriate EB/EIP level for your program.

7. Record the program/practice information for each funded program in County Self-Assessment Report, System Improvement Plan and OCAP Annual Reports.

8. CBCAP funded activities such as public awareness and brief information and referral activities are not required to be rated for effectiveness at this time.

Programs or practices that do not meet the threshold for Level I will be counted as Level 0:	LEVEL 0
1. The program is not able to articulate a theory of change which specifies clearly identified outcomes and describes the activities that are related to those outcomes.	
2. The program does not have a book, manual, other available writings, training materials that describe the components of the program.	
3. Two or more randomized, controlled trials (RCTs) have found the practice has not resulted in improved outcomes, when compared to usual care, OR	
4. If multiple outcome studies have been conducted, the overall weight of evidence does NOT support the efficacy of the practice, OR	
5. No evaluation has been conducted. The program may or may not have plans to implement an evaluation.	

>>>> Next Page for Level 1-4 Decision Tree >>>>

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Follow instructions on reverse to determine your program/practice level.

CHARACTERISTICS	EMERGING LEVEL 1	PROMISING LEVEL 2	SUPPORTED LEVEL 3	WELL-SUPPORTED LEVEL 4
1. The program can articulate a theory of change which specifies clearly identified outcomes and describes the activities that are related to those outcomes. This is represented through a program logic model or conceptual framework that depicts the assumptions for the activities that will lead to the desired outcomes.				
2. a. Level 1 or 2: The program may have a book, manual, other available writings, training materials, OR the program may be working on documents that specify the components of the practice protocol and describes how to administer it. b. Level 3 or 4: The practice has a book, manual, training, or other available writings that specificies the components of the practice protocol and describes how to administer it.				
3. The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving child abuse prevention or family support services.				
4. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.				
5. The program is committed to and is actively working on building stronger evidence through ongoing evaluation and continuous quality improvement activities.				
6. Programs and practices have been evaluated using less rigorous evaluation designs that have with no comparison group, including "pre-post" designs that examine change in individuals from before the program or practice was implemented to afterward, without comparing to an "untreated" group OR an evaluation is in process with the results not yet available.				
7. At least one study utilizing some form of control or comparison group (e.g. untreated group, placebo group, matched wait list) has established the practice's efficacy over the placebo, or found it to be comparable to or better than an appropriate comparison practice, in reducing risk and increasing protective factors associated with the prevention of abuse or neglect. The evaluation utilized a quasi-experimental study design, involving the comparison of two or more groups that differ based on their receipt of the program or practice. A formal, independent report has been produced which documents the program's positive outcomes.				
8. The program is able to provide formal or informal support and guidance regarding program model.				
9. Programs continually examine long-term outcomes and participate in research that would help solidify the outcome findings.				
10. The local program can demonstrate adherence to model fidelity in program or practice implementation.				
11. The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.				
12. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.				
13. If multiple outcome studies have been conducted, the overall weight of the evidence supports the effectiveness of the practice. (If screening for Level 3 and not applicable you may skip this question.)				
14. The detailed logic model or conceptual framework depicts the assumptions for the inputs and outputs that lead to the short, intermediate and long-term outcomes.				
15. The research supporting the efficacy of the program or practice in producing positive outcomes associated with reducing risk and increasing protective factors associated with the prevention of abuse or neglect meets at least one or more of the following criterion: a. At least two rigorous randomized controlled trials (RCTs) in highly controlled settings (e.g. univerisity laboratory) have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, peer-reviewed literature. OR b. At least two between-group design studies using either a matched comparison or regression discontinuity have found the practice to be equivalent to another practice that would qualify as supported or well supported; or superior to an appropriate comparison practice.				
16. Multiple Site Replication is Usual Practice Settings: At least two rigorous randomized controlled trials (RCTs) or comparable methodology in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published peer-reviewed literature.				

Follow instructions on reverse to determine your program/practice level.